

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004723

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 57 STATE FILE NUMBERVS 300
Rev. 4/5914002240232

3

4 15 2

6

7 08 294200H

10

11

1245-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) CLAYTON		c. CITY OR TOWN FRONTENAC	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSPITAL		d. STREET ADDRESS 10412 GERMAN BLVD.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARY		4. DATE OF DEATH Month JAN. Day 5 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Jesse Joles		13b. MOTHER'S MAIDEN NAME Elizabeth Boswell	14. NAME OF HUSBAND OR WIFE Richard (Dcd)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates) No		16. SOCIAL SECURITY NO. 1205 N. 89 St.	
17. INFORMANT Mrs. Anna QHagen		Address E. St. Louis, Ill.	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Carcinoma of the Skin			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour 12 a.m. 45 p.m. Month, Day, Year JAN 2, 1963		20d. INJURY OCCURRED: WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. Louis Co Mo.	
21. I attended the deceased from JAN 2, 1963 to JAN 5, 1963 and last saw her alive on JAN 5, 1963 Death occurred at 12 45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H.R. Gilson, M.D.		22b. ADDRESS 601 So. Brentwood	22c. DATE SIGNED 1-7-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-7-63	23c. NAME OF CEMETERY OR CREMATORY Fee Fee
24. FUNERAL DIRECTOR Baumann Bros.		25. DATE RECD. BY LOCAL REG. 1-7-63	26. REGISTRAR'S SIGNATURE John Murphy M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3454

P. O. Address St Louis 14, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.